State Missouri

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary

a. Transportation

Emergency ambulance service is provided under Medicaid when an emergency medical situation exists, the recipient is transported to the nearest appropriate hospital or emergency room, and the patient could not be safely transported by any other means.

Transportation by ambulance to or from a physician's or dentist's office, an independent clinic or an independent laboratory, are not covered services. Ambulance service to a patient's home and transportation by air ambulance are also non-covered services.

Refer to Attachment 3.1-A, page 10d for coverage under EPSDT.

d. Skilled Nursing Facility Services for Patients Under 21 Years of Age

Skilled nursing facility services are available to those recipients under 21 who have been certified by a State Medical Consultant as requiring a skilled nursing level of care. Duration of service is conditional upon periodic, subsequent recertification.

f. Personal Care Services

Personal Care Services are medically oriented services provided in the individual's home, or in a licensed Residential Care Facility I or II to assist with activities of daily living. Personal care services are prescribed by a physician, are provided in accordance with an individual plan of care, and are supervised by a registered nurse.

1. Personal care services as an alternative to institutional care:

Personal Care Service is provided on a scheduled basis to eligible recipients in their own homes or in a licensed Residential Care Facility I or II as an alternative to a state agency determined need for twenty-four hour institutional care on an inpatient or residential basis in a hospital or nursing facility. Coverage of service requires and is in accordance with a personal care plan and an in-home assessment of need which must be completed at least every six months. Services must be supervised by an RN who must visit a 10% sample of caseload monthly, which visits will not be reimbursed, and must also at the authorization of the state agency's case mnaager make additional visits which will be reimbursed to provided enhanced supervision and certain other functions necessary to the maintenance of the recipient in his home.

State Missouri

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary

f. Personal Care Services (con't)

1. Con't.
The Personal Care Service includes an advanced level of Personal Care, which provides assistance with activities of daily living to individuals with chronic and stable conditions, who require devices and procedures related to altered body functions. Recipients in need of Advanced Personal Care will be assessed by the provider agency RN for care plan development. Recipients in need of Advanced Personal Care may receive ongoing RN visits not to exceed weekly in frequency. The RN visits are reimbursable and provide enhanced supervision of the aide and continued assessment of the recipient's needs.

2. Mental Health Residential Personal Care:

The Personal Care Service includes a specialized level of personal care assistance, called Mental Health Residential Personal Care, for persons with serious mental illness and developmental disabilities who require care and procedures on a 24 hour basis related to diminished mental or physical capacities. This services includes both basic and advanced personal care activities provided in accordance with a physician-approved plan of care, supervised by an RN and provided by qualified staff licensed by the Department of Mental Health. Provision of this service requires additional training and supervision of aides, and additional time devoted to care of the individual due to specialized needs, increased difficulty with communication and occasional aggressive and disrupting behaviors. Providers must be licensed by the Department of Mental Health as Community Residential Facilities. Eligible clients are those who are Medicaid eligible, are assessed to need the required level of care and are admitted to an enrolled facility. Clients are assessed and care plans developed by staff of the Department of Mental Health and its administrative agents.

State Missouri

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary

f. Personal Care Services (con't)

3. Vocational Rehabilitation Personal Care Assistance

The Personal Care Services includes a specialized level of personal care assistance for persons who qualify for vocational rehabilitation services administered by the Department of Elementary and Secondary Education, Division of Vocational Rehabilitation. Persons eligible for personal care assistance must be employed or ready for employment, capable of living independently with personal care assistance, and have a documented need for PCA of between seven and forty-two hours per week. Services include assistance with activities of daily living, provided by a qualified and trained aide in accordance with a plan of care approved by a physician. Providers of Personal Care Assistance must have a contract with the Division of Vocational Rehabilitation as a Center for Independent Living as a condition of Medicaid Enrollment. The Centers assess the client's needs and develop the care plan using a team of professionals including a registered nurse, physical or occupational therapist, a case manager employed by the Division of Vocational Rehabilitation and others. Clients select, hire, train and supervise their own aides, with assistance, supervision, and oversight from the Center for Independent Living. Medicaid recipients who do not meet the criteria for Personal Care Assistance specified in this subsection of the State Plan will be referred to the appropriate state agency for assessment for personal care services under numbers 1 or 2 above, depending upon the needs of the recipient.

Nurse Practitioner Services

Nurse practitioner services are limited to those services provided by properly licensed and certified pediatric nurse practitioners, family nurse practitioners, and obstetrical and gynecological nurse practitioners practicing within the scope of state law.

A new patient office visit is limited to one per provider for each recipient. An established patient extended or comprehensive visit is limited to one per provider per year for each recipient.

Other nurse practitioner limitations apply as set forth in the Nurse practitioner Provider Manual.

State Missouri

26. Program of All-Inclusive Care for the Elderly (PACE)

Citation 1905(a)(26) and 1934

___X___Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

A Program of All-Inclusive Care for the Elderly (PACE) program begins initially as a Prepaid Health Plan (PH) with only selected Medicaid services under partial capitation (such as home care, nursing facility care, physician, pharmacy, and some of the optional state plan services) while acute care and other Medicare-covered services remain billable to both Medicare and Medicaid.

Fully capitated PACE is a comprehensive, intergrated, managed care system for very frail older persons. PACE is an integrated service system that includes primary care, restorative therapy, transportation, home health care, inpatient acute care, and even long term care in a nursing facility when home and community-based services are no longer appropriate. Services are provided at the PACE center, the home, or in the hospital, depending upon the needs of the individual. Enrollment in a PACE program is always voluntary and participants have the option to disenroll and return to the fee-for-service system at any time.

The target population for this program includes: individuals age 55 and older, identified by the Division of Aging through health status assessment, specific types of assistance, and nursing home levels of care. The Division of Aging will assess potential eligible persons using Nursing Facility level of care assessment criteria.

To be considered eligible to contract as a PACE provider, a provider must:

- Conduct a feasibility study and be recognized by the National PACE Association as an approved PACE development entity;

- Agree to seek Medicare Section 222 waivers in sufficient time to obtain approval of the waiver requests within two years of the effective date of the provider's contract with the state (this will change with Balanced Budget Act of 1997);
- Accept the provisions of the PACE Protocol including its reimbursement provisions;
- Have established referral arrangements with Medicaid participating service providers which include: inpatient hospital services, outpatient hospital services, home health and laboratory and x-ray services;
- Have sufficient contracts in place to provide all covered services;
- Agree to participate with the state agency in the development of a Section 1115 waiver to be submitted concurrently with the provider's Medicare Section 222 waivers; and
- Pursue and obtain Missouri HMO licensure through Missouri Department of Insurance.

Missouri has entered into a pre-PACE contract with Alexian Brothers Community Services (ABCS) of St. Louis designed to create a Prepaid Health Plan (PHP) which capitates nursing facility, physician, pharmacy, and other optional state plan services. This prepaid health plan approach to PACE replication has been approved by the Health Care Financing Administration (HCFA). The pre-PACE contract allows the provider to start with low enrollment to gain experience in managing a risk-based, capitated managed care program. Services will be provided to eligible individuals who reside in a limited area of St. Louis City and County, Missouri.

State Missouri

The following additional prior authorization requirements are in effect:

1. Human Organ and Bone Marrow Transplants and Related Transplantation Services -

For human organ or bone marrow transplants and related transplantation services as specified in this part, the State agency has written standards regarding the provision of these services and benefits available. These standards are included, and further incorporated by reference in Attachment 3.1-E, as in state rule 13 CSR 70-2.200. The standards are applied on a case-by-case basis in a manner which insures that individuals similarly situated receive similar treatment and that any restrictions imposed under the standards on the facilities and practitioners are consistent with the accessibility of high quality care to eligible individuals.

2. Inpatient Hospital Services

Program coverage for bone marrow, heart, kidney, liver, lung and certain restricted multiple organ transplants involving an organ on the approved list and related transplantation services requires prior authorization and must be performed at a Medicaid approved center.

2.a. Outpatient Hospital Services

Prior authorization is required for:

- Admission for plastic surgery when performed in connection with the improvement of the functioning of a malformed body member or the correction of a visible disfigurement which would naturally affect the person's acceptance by society. (Accident injury or congenital anomalies).

- Dietary supplement.

5. Physician services

Prior authorization is required for the following surgical procedures:

- Plastic surgery performed in conjunction with accidental injuries resulting in the functional loss of body members, malformed body members, or a visible disfigurement which would naturally affect the person's acceptance by society.

- Surgical reconstruction for correction of congenital anomalies or visible disfigurement resulting from a traumatic injury.

- Reduction mammoplasty for alleviation of severe back pain.

- Prior authorization is also required for dietary supplement.

Program coverage for bone marrow, heart, kidney, liver, lung and certain restricted multiple organ transplants involving an organ on the approved list and related transplantation services requires prior authorization and must be performed at a Medicaid approved transplant center.

9. Clinic Services

Prior authorization is required for the following surgical procedures:

- Plastic surgery performed in conjunction with accidental injuries resulting in the functional loss of body members, malformed body members, or a visible disfigurement which would naturally affect the person's acceptance by society.

- Surgical reconstruction for correction of congenital anomalies or visible disfigurement resulting from a traumatic injury.

- Reduction mammoplasty for alleviation of severe back pain.

- Prior authorization is also required for dietary supplement.

Program coverage for bone marrow, heart, kidney, liver, lung and certain restricted multiple organ transplants involving an organ on the approved list and related transplantation services requires prior authorization and must be performed at a Medicaid approved transplant center.

State Missouri

Prior Authorization Requirement of General Application

Prior Authorization is required for all non-emergency Medicaid covered services which are received by recipients in states other than Missouri and it's bordering states. Medical services which are exempt from this Prior Authorization requirement are:

(1). Those services provided to Foster Care children;
(2). Those services provided recipients having concurrent Medicare and Medicaid eligibility if Medicare does allow the service and provides primary payment;
(3). Emergency ambulance services;
(4). Independent laboratory services.

DIABETIC EDUCATION AND SUPPLIES

Medically appropriate and necessary equipment, supplies and self-management training used in the management and treatment of type 1, type 2 and gestational diabetes are covered when prescribed by a physician.

Diabetes self-management training services are limited to any of the following circumstances:

- initial diagnosis of diabetes;
- any significant change in the patient's symptoms, condition or treatment; or
- documented need for re-education or refresher training.

Self-management training may be provided by a Certified Diabetes Educator, Registered Dietician, or Registered Pharmacist and must be ordered by a physician or a health care provider with prescribing authority.

#19 See limitation on Description

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Missouri

#19

CASE MANAGEMENT SERVICES

A. Target Group:

See [redacted]

B. Areas of State in which services will be provided:

/X/ Entire State.

/ / Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

/ / Services are provided in accordance with section 1902(a)(10)(B) of the Act.

/X/ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See page 1a-1, 1a-2

E. Qualification of Providers:

See page 1a-2, 1a-3

A. Target Group: All Medicaid eligible pregnant women assessed as being at risk of an unfavorable physical, developmental and/or psychosocial outcome.

D. Definition of Services: (contd.)

Case management is a system under which responsibility for locating, coordinating, and monitoring a group of services rests with a designated person or organization in order to promote the effective and efficient access to necessary comprehensive services. Case management can be conceptualized as a set of individual client goal oriented activities which organize, coordinate, and monitor service delivery based on measurable objectives.

Case management services for pregnant women are focused toward the reduction of infant mortality and low birth weight by reducing the inadequate prenatal care rate. This is accomplished by educating the client and following non-compliant pregnant women so that they will more closely follow the recommendations of their care providers. An increase in women who receive adequate prenatal care will result in fewer drop-in, high-risk and at-risk deliveries thereby reducing the percentage of negative pregnancy outcomes.

Limitation on Services -

One risk appraisal will be reimbursed during a pregnancy and should be performed during the initial visit to the medical care provider. One additional risk appraisal may be reimbursed when a pregnant woman was previously appraised as not being at risk and her medical condition changes.

A Risk Appraisal for Pregnant Women may not be billed in addition to comprehensive office services, extended office services, global prenatal or global delivery as the risk appraisal is included in the reimbursement amount for the visit or global service. It may be billed on the same date of service as a lesser level of service visit.

Medicaid will reimburse only one (1) case management fee per calendar month. Case management services may be reimbursed during the two months immediately following delivery.

Case management services are not reimbursable if the recipient is hospitalized and the services are rendered during the period of hospitalization.

Case management services are not reimbursable if the recipient is not Medicaid eligible on the date of service.